



COUNSELING ASSESSMENT FOR HIV, STD AND HEPATITIS C TESTING

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF DISEASE CONTROL
SFN 58941 (4-2015)

This form should be used as a guide by the counselor when testing clients for HIV and/or Hepatitis C. Client and counselor should review risk assessment document together to assess testing and risk-reduction needs.

Date

Client Information

| | | |
|-----------|------------|---------------|
| Last Name | First Name | Date of Birth |
| Address | Occupation | Phone Number |

Pre-Test Counseling Assessment

Explanation of Testing

- ☐ Discuss confidentiality issues.
- ☐ Explain what a negative test result means.
- ☐ Explain what a positive test result means.
- ☐ Review risk assessment form and discuss testing recommendation(s).
- ☐ Informed consent for testing signed and dated.

Testing Device

| | |
|--|--|
| <input type="checkbox"/> Venipuncture Site _____ | Safer Sex and Educational Materials Distributed |
| <input type="checkbox"/> OraQuick® Rapid HCV _____ | <input type="checkbox"/> Hepatitis C Fact Sheet <input type="checkbox"/> Condom User Guide |
| <input type="checkbox"/> Clearview® Complete Rapid HIV _____ | <input type="checkbox"/> STD Facts Brochure <input type="checkbox"/> Lubrication |
| <input type="checkbox"/> Urine _____ | <input type="checkbox"/> Oral Sex Brochure <input type="checkbox"/> Condoms |
| | <input type="checkbox"/> HIV Facts Brochure <input type="checkbox"/> Female Condoms |
| | <input type="checkbox"/> HIV/AIDS Transmission <input type="checkbox"/> Safer Sex Kit |
| | <input type="checkbox"/> Dental Dam <input type="checkbox"/> Other |

Risk Reduction Plan

| | |
|---|---|
| <input type="checkbox"/> Assess and discuss risk factors for HIV/HCV infection. | Options Available for Reducing Risk of HIV/HCV |
| <input type="checkbox"/> Assess client's intention to modify risky behaviors. | <input type="checkbox"/> Monogamous Relationship |
| <input type="checkbox"/> Explain purpose of a risk reduction plan. | <input type="checkbox"/> Limiting Sexual Partners |
| <input type="checkbox"/> Confirm with client plan is realistic and feasible. | <input type="checkbox"/> Consistent Usage of Condoms |
| <input type="checkbox"/> Identify and discuss previous prevention failures. | <input type="checkbox"/> Avoid Sharing Needles/Drug Paraphernalia |
| <input type="checkbox"/> Discuss barriers to safer behavior. | <input type="checkbox"/> Demonstration of Condom Usage |
| <input type="checkbox"/> Reinforce and support positive prevention choices. | <input type="checkbox"/> Use of Condoms/Dental Dams for Oral Sex |
| <input type="checkbox"/> Safer goal behaviors and action plan given to client. | <input type="checkbox"/> Condoms Offered |
| | <input type="checkbox"/> Avoid drugs and alcohol (HCV – Support Liver Health) |

Test Result

| | |
|---|-------------|
| HIV Test Result <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Positive | Date: _____ |
| HCV Test Result <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Positive | Date: _____ |
| STD Test Results Chlamydia <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Positive Gonorrhea <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Positive Syphilis <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Positive | Date: _____ |
| Copy of test results given to client? <input type="checkbox"/> Yes Date Given _____ <input type="checkbox"/> No Why? _____ | |

Negative Test Results

| | |
|--|---|
| <input type="checkbox"/> Explain the validity of a negative result. | <input type="checkbox"/> Review strategies for risk reduction. |
| <input type="checkbox"/> Recommendation to re-test in 1 year, depending on risk. | <input type="checkbox"/> Review resources for support, treatment, & counseling. |
| <input type="checkbox"/> Address any questions related to the test. | <input type="checkbox"/> Provide referrals if necessary. |
| <input type="checkbox"/> Review assessment of risk factors from pre-counseling. | |

If the Clearview® Complete or Orasure® HCV rapid test is preliminary positive (reactive) please submit a confirmatory test to the State Lab and provide the following information to the HIV and/or Hepatitis Program. Please contact NDDoH with rapid positive result immediately.

HIV and/or HCV Confirmation Test (Rapid HIV or HCV Preliminary Positive)

| |
|---|
| <input type="checkbox"/> Venipuncture Date Collected _____ |
| <input type="checkbox"/> Scheduled return for results _____ |
| <input type="checkbox"/> Notified the HIV/AIDS Program or Hepatitis Program Date _____ Personnel _____ |
| <input type="checkbox"/> Fax a copy of the preliminary positive test result to the HIV or Hepatitis Program, confidential fax at 701.328.0356 |

Positive Test Results (OraQuick® Rapid HCV or Clearview® Complete Rapid HIV Positive and Confirmatory Positive)

| | |
|---|---|
| <input type="checkbox"/> Assess client's readiness to receive results. | Provide appropriate referrals: |
| <input type="checkbox"/> Explain the meaning and validity of a positive test. | <input type="checkbox"/> Medical evaluation with: _____ |
| <input type="checkbox"/> Address any questions related to test results. | <input type="checkbox"/> TB Testing |
| <input type="checkbox"/> Client to notify sexual/drug contacts. | <input type="checkbox"/> STD Testing |
| <input type="checkbox"/> Review risk reduction plan. | <input type="checkbox"/> Hepatitis Testing/Vaccination |
| <input type="checkbox"/> Notified the HIV/AIDS Program or Hepatitis Program Date _____ Personnel _____ | <input type="checkbox"/> Mental Health |
| | <input type="checkbox"/> ND CARES Program |
| | <input type="checkbox"/> CAP Case Management |

Counselor's Signature

| | |
|-------|-------|
| _____ | _____ |
| Name | Date |